DOCUMENT RESUME

ED 134 309 PS 009 015

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TITLE	Head Start/EPSDT Collaboration Evaluation: Final Report. Executive Summary.
INSTITUTION	Boone, Young and Associates, Inc., New York, N.Y.
SPONS AGENCY	Office of Child Development (DHEW), Washington, D.C.
PUB DATE	Aug 76
CONTRACT	OCD-105-74-1101
NOTE	29p.; Revised edition; For related documents, see ED 133 069 and ED 133 070
EDRS PRICE	MF-$0.83 HC-$2.06 Plus Postage.
DESCRIPTORS	Cost Effectiveness; *Demonstration Programs; Dental Health; *Early Childhood Education; Evaluation Methods; Financial Support; *Health Programs; *Health Services; Medical Services; Nutrition; Policy; *Program Evaluation; Screening Tests; Welfare Services
IDENTIFIERS	Early Periodic Screening Diagnosis and Treatment; EPSDT; *Medicaid; *Project Head Start

ABSTRACT

This is the executive summary of the final report on the first year evaluation of the Head Start/Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Collaborative Effort, a demonstration program initiated by the Office of Child Development (OCD)/HEW in 1974. In initiating the program, OCD/HEW set forth the following objectives: (1) to assess the benefits in terms of increased services for both Head Start and non-Head Start children and to establish the dollar value of these services; (2) to determine any barriers which prevent the Head Start program from making maximum use of Medicaid/EPSDT to pay for required health services provided to Medicaid eligible children in local programs; (3) to analyze long-term program and policy issues concerning Head Start services to young children as a basis for improving those services in Head Start/Medicaid EPSDT. This executive summary presents major findings and issues of the study that may be pertinent to the interest of OCD policymakers and program administrators, as well as others concerned with quality child development and health services. (Author/MS)

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PS009015

This Report was Prepared for:

Department of Health, Education and Welfare
Office of Child Development

Under Contract No. 105-74-1101

Dr. Bernard Brown, Project Officer

HEAD START/EPSDT COLLABORATION EVALUATION: FINAL REPORT

EXECUTIVE SUMMARY

Policy Relevant Findings and Considerations

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June 1976

(Revised August 1976)

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Introduction

The Office of Child Development (OCD)/HEW contracted with Boone, Young & Associates, Inc. to conduct an evaluation of the first year operation of the Head Start/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Collaborative Effort, a demonstration program launched by OCD in January 1974. The findings and recommendations resulting from the evaluation of this program were presented to OCD in the March 1976 Final Report: Head Start/EPSDT Collaboration Evaluation, Contract No. 105-74-1101. This executive summary presents the major findings and issues of the study that may be pertinent to the interest of OCD policymakers and program administrators, as well as others concerned with quality child development and health services.

To accomplish the objectives of the collaborative effort, OCD awarded supplemental grants to 200 Head Start projects early in 1974. (Two projects subsequently declined to participate.) All demonstration projects were required to assure Medicaid certification for as many Medicaid eligible Head Start children as possible. As a second but important priority, the projects were instructed to recruit non-Head Start, Medicaid eligible children for the EPSDT program.

The evaluation study focused upon the extent to which the demonstration projects utilized Medicaid EPSDT as a source for health services--either as a provider or source of payment--for Head Start and non-Head Start children. In addition, the organizational and operational aspects of the demonstration, and the scope and nature of EPSDT services available under the state plan as compared to the OCD Head Start Program Performance Standards, were reviewed. Thirty projects were selected from the national study group for in-depth analysis.

For the demonstration projects, the first year operation was primarily a start-up period. Many projects actually experienced difficulty in carrying out the demonstration because of lack of clarity about its objectives, e.g., the extent that resources should be assigned to recruiting and providing services to non-Head Start children. The inadequacy of community health resources and the lack of information about local EPSDT services also proved, in many instances, to be critical barriers to the full implementation of the collaborative effort.

Given these factors, the projects did quite well in recruiting Head Start and non-Head Start children to participate in the demonstration. An extrapolation for the 198 projects, based upon the various study instruments submitted, indicates that approximately 129,234 children were screened in the 198 projects during the first year (111,502 Head Start and 17,732 non-Head

Start). For diagnostic or treatment services received, the extrapolated number is 26,933 children (22,511 Head Start and 4,422 non-Head Start).

In assessing the objectives of the demonstration program, three broad policy issues emerged:

- Can Head Start play a role in the delivery of preventive health services to low-income, preschool children?
- Is EPSDT a viable resource for obtaining health services for Head Start children?
- Is the collaborative effort a specific program model which is replicable nationwide?

Because health services is one of its four mandated program components, these issues have major policy and program implications for Head Start. Each local Head Start project is required to provide the range of health services specified in the OCD Head Start Program Performance Standards; thus, each project expends considerable staff and other resources in this regard. If the Head Start projects could better utilize child health service resources such as EPSDT, then resources currently allocated to health services could be shifted to other health program uses. Of even greater significance is the potential role of Head Start in providing integrated community services to improve the health care status of the family of the Head Start child through linkages with a variety of community health resources.

This executive summary addresses these policy issues. The findings and conclusions presented have been extracted from the interim and final reports submitted to OCD. The demonstration progam itself is in its second year of operation, and the evaluation study is being continued.

Overview: Head Start/EPSDT Collaborative Effort

The Head Start/EPSDT Collaborative Effort developed out of recognition by OCD and SRS administrators that the outreach activities to ensure maximum utilization of EPSDT by low-income preschool children could be carried out more effectively through community-based agencies. Head Start, as a comprehensive child development program, uniquely provided the mechanism by which such activities could be mounted. Head Start clearly was indentified as a service for low-income preschoolers; its staff also had a wealth of experience in recruitment and outreach strategies. Moreover, Head Start children themselves were a potential source for EPSDT participation if they met Medicaid eligibility requirements.

The EPSDT program had been initiated in 1968 as a preventive child health program through passage of amendments to the Medicaid provisions (Title XIX) of the Social Security Act. Envisioned as a broad-based screening and treatment program for low-income children from 0-21 years, EPSDT had fallen short of its anticipated goals for several reasons, including:

- delay in issuance of federal regulations
- reluctance of states to assume the additional costs inherent in implementing a preventive health program
- inadequate supply of health service providers
- lack of well planned, well structured, comprehensive community health systems at the state or local level.

The major objectives of the collaborative effort were to:

- increase the numbers of low-income, preschool children receiving EPSDT
- strengthen the Head Start health service component
- maximize use of Medicaid as a payment source for health services provided to Medicaid certified Head Start children
- establish replicable models for bringing about collaboration among Head Start, public EPSDT agencies and related community health resources.

The supplemental grants awarded by OCD to the demonstration projects ranged from $500 to $16,500, and were based upon decisions made at the regional level. The projects had to submit proposals outlining ways they would carry out the demonstration and describing the potential/actual Medicaid population in Head Start and the surrounding community. The amount of the grant awarded, however, bore little relation to the size of the local Head Start project or the number of children to be served.

For day-to-day operations a specific staff person was assigned to coordinate the collaborative effort. This responsibility included recruiting and informing families about EPSDT services, arranging for other supportive services, and acting as a liaison between the family and cooperative agencies.

Overview: Head Start/EPSDT Collaboration Evaluation

The first year evaluation was primarily a descriptive analysis of the collaborative effort based upon information gathered from the national sample. The survey design consisted of mailed questionnaires to all participating projects to determine the extent of participation of Medicaid eligible and non-eligible children and factors related to operating the collaboration, including staffing and costs. In addition, more detailed information on the health care of individual participating children and associated costs were collected from the selected sample. Also, on-site visits were made to the selected projects to solicit more qualitative information about program operation. During the first year of the evaluation, 147 out of the 198 funded projects submitted the requested data by mail, and site visits were made to 24 of the projects in the selected sample.

The thirty projects which were analyzed in-depth were chosen within the twelve target states designated by OCD for examination of their EPSDT plan and services. The criteria for selecting projects for intensive analysis included:

- presence of institutional barriers to implementation of EPSDT
- characteristics aspects of delivery of health care to children
- rural/urban characteristics
- program size
- program sponsorship
- geographic dispersion within the state.

Many of the projects in the demonstration were located in rural areas; therefore, the selection of projects for intensive analysis attempted to correct for this basis. The selected projects ranged in of children served from 66 to 2,500. Head Start projects serving Indian and migrant workers' children were also included.

The study variables for the evaluation were:

- planned participation by actual participation at intake and anytime during the year
- Medicaid eligibility/certification prior to for all seven service categories.)
- Medicaid eligibility/certification during the first year
- health care (medical, dental, mental health and nutritional) prior and during the first year
- staff characteristics: educational and experience background
- provision of supportive services--outreach follow-up, recordkeeping, transportation--for participating children

- costs--direct and indirect--of the collaboration by revenue/expenditure

The study tasks focused upon the extent that the projects were able to accomplish the objectives of the collaborative effort, with particular emphasis upon documentation of the EPSDT services provided to/obtained for Head Start and non-Head Start children as a result of the demonstration. For this purpose, information was collected on the health care received by participating children prior to and during the program year by Head Start enrollment and Medicaid certification status. For non-Head Start children, their kinship to Head Start enrollees was also recorded, as well as their Medicaid certification status. OCD also requested that information be provided on the kind and extent of supportive services provided to Head Start and non-Head Start children.

The study included the total Head Start population ages 0-6, and compared Head Start, Medicaid eligible children with those not Medicaid eligible by their health care status. Similiar analysis was performed for the non-Head Start population. Comparability between Head Start Program Performance Standards and services covered under EPSDT state plans was an important study task for analysis because of the need to examine additional resources (if any) provided by Head Start projects to meet Head Start standards for health services.

On-site visits were made to cooperating EPSDT agencies and providers as well as to the selected projects. Interviews were used to solicit information on start-up activities, relationships to EPSDT agencies and other qualitative aspects of the demonstration program. The visits also provided the opportunity to check on the reliability and validity of the information submitted on the forms and to review the adequacy of the recordkeeping systems.

Major Findings

Three broad policy issues were identified earlier in this report:

- Can Head Start play a role in the delivery of preventive health services to low-income, preschool children?
- Is EPSDT a viable resource for obtaining health services for Head Start children?
- Is the collaborative effort as a specific program model replicable nationwide?

These issues offer a framework within which to formulate specific questions for presenting the major findings and the policy considerations stemming from the first year evaluation. These questions are:

- How effective were the projects in obtaining health services for Head Start and non-Head Start children?
- How effective were the projects in providing outreach, follow-up, recordkeeping and transportation services for non-Head Start children?

- How effective were the projects in obtaining Medicaid certification for Head Start and non-Head Start children?
- In what way were the Head Start requirements for health services comparable to those mandated through EPSDT state plans?
- What were the income and expenditure costs associated with implementing the collaborative effort?
- What organizational/operational changes took place in the local projects in carrying out the collaborative effort?
- How could Head Start make more effective use of EPSDT as a program resources?

Each of these is discussed below.

How effective were the projects in obtaining health services for Head Start and non-Head Start children?

FINDINGS:

- There was a fourfold increase in the number of children screened this year compared to last year. The vast majority of children screened (86% or 82,782 out of 95,997) were Head Start enrollees. Most of these screenings, however, were incomplete at the time of reporting. Although there was an increase in the number of non-Head Start children screened, it was not as great.

- Although relatively large numbers of children were screened, only one out of five were diagnosed or treated. For those treated, acute or chronic care was most often provided for both Head Start and non-Head Start children; and each child received 2.6 units of treatment.

- Nearly all of the previously enrolled Head Start children (92% or 6,792 out of 7,343) had received screening services, primarily through Head Start, prior to entry into the EPSDT effort, and Medicaid certification or eligibility was not a factor in receipt of these services.

- Few projects reported children--Head Start or non-Head Start--who had received mental health, medical, and nutritional services prior to entry into EPSDT.

- Non-Head Start children who had recived health services prior to entering EPSDT were primarily Medicaid certified and siblings of Head Start enrollees.

PROBLEMS:

- The availability of particular health services in a given area again influenced the incidence of their receipt this year, particularly psychological and nutritional services.

- Lack of information about the nature or quality of screening and other health services provided limits assessment of the impact of these services upon the health status of the children.

- The relatively large number of Head Start children participating who were ineligible for Medicaid or were of unknown status means that the Head Start projects most likely had to pay for services rendered from their own program resources, even if the services were avilable through the state EPSDT plan.

- As in the case of the previous year, dental care was the most prevalent type of health service provided. Moreover, there was a fourfold increase in the number of children reported this year.

- More than 90% (8,800 out of 9,623) of the Head Start and non-Head Start children who were reported as having mental health services received psychological testing type of test administered unknown), but few were counseled or referred for further services.

- Nutritional services were again the least frequently provided. A greater number of children receiving these services were referred for additional assessment compared to other health services.

- Medicaid certification appeared to be unrelated to the receipt of health services, as the proportion of Head Start and non-Head Start Medicaid certified children was almost equal to those who were ineligible or of unknown status.

- The availability of various health services in a local area, with some communities apparently having significantly greater resources than others, may have determined the incidence of prior health care to some degree in any particular region.

- The similarity in incidence between Head Start and non-Head Start children who received screening services prior to EPSDT entry may reflect the concentration by some Head Start programs in providing family health services rather than focusing on the needs of the enrolled Head Start child, alone. Apparent emphasis in the projects on supplying dental services for Head Start enrollees may explain the relatively lower rate of dental care for non-Head Start children.

POLICY CONSIDERATIONS:

- The screening package mandated for Head Start children might be defined in greater detail (test specification, for instance) to assure measures of comparability among Head Start programs, as has been reflected in the 1975 revision of the Head Start Performance Standards.

  Further studies regarding the quality of health services received could provide the basis for revising standards for health care.

- Additional program resources for Head Start projects would greatly enhance their capability in providing services to families of Head Start children. The parent involvement component could be particularly useful toward this end.

- Head Start programs might be encouraged to arrange for family health services, thereby ensuring that all family members, including children, are provided comprehensive care. Similarly, the projects could be assisted in defining their responsibility for recruiting participants beyond the immediate Head Start family as part of the Head Start Performance Standards.

- Limitations in some state plans for Medicaid/ EPSDT could be overcome through implementation of national standards for the provision of health services to low-income, pre-school children.

- Greater assistance for Head Start programs in improving utilization of community health resources would result in expanded screening services through augmentation of the programs' own capabilities.

- Additional assistance for Head Start programs would enable them to become more aware of the overall developmental health of pre-school children. Particular stress could be placed on nutritional and mental health development.

How effective were the projects in providing outreach, follow-up, recordkeeping and transportation services for non-Head Start children?

FINDINGS:

- There were limitations on the level and adequacy of supportive services provided to non-Head Start children. The Head Start projects were the major providers of these services to non-Head Start children, suggesting a general understanding of the intent of the EPSDT Collaborative Effort. The parent involvement component was the most effective tool in outreach to non-Head Start children.

PROBLEMS:

- Previous approaches to providing supportive services in the Head Start programs were generally maintained during the collaborative effort, limiting the provision of supportive services to non-Head Start population.

- Public agencies tended to focus their supportive services on follow-up rather than outreach, again limiting the number of non-Head Start children served. The voluntary sector proved to be of minimal help to the projects in delivering supportive services.

- The non-Head Start child was less likely to receive follow-up services, particularly verification, possibly related again to emphasis by the projects on previous patterns of supportive services delivery.

- Recordkeeping for non-Head Start children was considerably weaker than for Head Start children, possibly the result of a lack of resources in the projects.

POLICY CONSIDERATIONS:

- Better coordination between Head Start projects and public agencies would provide more consistent and expanded delivery of supportive services to non-Head Start children. The projects might also seek reimbursement for these services, provided they are part of the state EPSDT plan.

- Head Start projects might be encouraged to utilize more fully whatever resources are available in the voluntary sector for delivery of supportive services, particularly in the areas of outreach.

- Head Start programs might be encouraged to use the parent involvement component to the fullest extent to ensure that all siblings of Head Start enrollees become participants in the EPSDT effort, thereby also expanding provision of supportive services. Likewise, door-to-door contact could be used more extensively as an outreach technique

- Requirement of recordkeeping on the provision of services to non-Head Start children by the projects would both maximize supportive service delivery and improve procedural quality in all aspects of the collaborative effort.

How effective were the projects in obtaining Medicaid certification for Head Start and non-Head Start children?

FINDINGS:

- Head Start projects were reasonably successful in reaching and reviewing children for Medicaid eligibility, but the majority of children--both Head Start and non-Head Start--Head Start/who were reported as Medicaid certified began the EPSDT Collaborative Effort with that status (60% or 17,989 out of 25,737).

The projects were more successful in reaching and reviewing non-Head Start children for Medicaid eligibility, but the majority of the non-Head Start youngsters were the siblings of Head Start enrollees who were already certified, rather than siblings in those Head Start families believed eligible but not yet certified.

- The projects were highly successful in obtaining Medicaid certification for non-Head Start children who had not been certified prior to entry into the collaboration (83%, or 10,178 out of 13,277). They were less successful with the Head Start population (38%, or 14,684 out of 38,912), reflecting possible discrepancies between the eligibility standards for Medicaid and Head Start.

- The parent involvement component was generally useful in providing for outreach, screening, and establishing Medicaid eligibility, particularly for the siblings of non-Head Start children.

- There were wide variations among regions and among selected projects in the numbers of children--Head Start and non-Head Start--for whom Medicaid certification was achieved.

PROBLEMS:

- Limited staff resources and the lack of clarity as to the degree of involvement by Head Start staff in the recruitment of non-Head Start, non-sibling children were apparently important adverse factors in reaching these children.

- The differences in eligibility standards for Medicaid and Head Start services may have affected the number of children who were found to be Medicaid eligible by the projects. States with appreciably low Medicaid standards may have been unable to accept low-income children recruited by the Head Start projects for the collabrative effort.

- Many children apparently experienced considerable fluctuation in their Medicaid status over the year, with possible detrimental results for health care continuity.

POLICY CONSIDERATIONS:

- Systematic planning, including reliable estimates of the number of children to be served and information on the type of supportive services available, would be likely to enhance certification efforts through improved deployment of staff resources.

- Local Head Start programs could use standardized procedures for assessing Medicaid eligibility, so that the accuracy of Medicaid certification referrals might be increased. Also, review could be undertaken by OCD of barriers to EPSDT eligibility for Head Start enrollees because of criteria.

- Head Start programs could establish closer working relationships with local EPSDT agencies to speed the determination and certification process of a referral child.

- The number of potentially eligible children brought into EPSDT could be increased were the projects given greater assistance in developing outreach techniques, and were greater stress placed on the demonstrably successful parent involvement component.

- Because the income eligibility differences (in dollars) tend to be minimal between Medicaid and Head Start, OCD may wish to review with SRS the feasibility of providing Medicaid certification to low-income, pre-school children on the basis of their enrollment in Head Start.

In what way were the Head Start requirements for health services comparable to those mandated through EPSDT plans?

FINDINGS:

- The state plans' description of supportive services are particularly limited, and may not provide the same degree of delivery as Head Start potentially could.
- There is no uniformity regarding the types and quality of services provided among the various states.
- State Medicaid/EPSDT plans were characterized by their complexity, with disparate delegation of responsibilities to different public and private agencies at both the state and local levels.
- There was overall failure by the Head Start programs to be integrated into the delivery of Medicaid/EPSDT services at the state or local levels by achieving vendor status.
- The collaborative effort had minimal impact on the institutional arrangements of a state Medicaid/EPSDT plan or program.

PROBLEMS:

- With the exception of California, none of the states provide a mechanism for consumer paritic pation in their EPSDT plans.
- Although most states cite the importance in their plans of coordination with existing health resources, none specify procedures for ensuring that linkage does occur.
- Lack of specificity and uniformity in regard to types and levels of service provided complicates the collaborative process for an agency such as Head Start, and necessitates a state by state analysis of the health benefit package.
- In those states which provide reimbursement for the entire screening package, Head Start, even if it achieves vendor status, may not be able to receive reimbursement unless it delivers the entire package of screening services.

- The format of many state plans is complex, and often the phrasing is ambiguous or obscure.

- Variations among state plans concerning their reimbursement policies can and do lead to alienation and frustration among vendors who apply for reimbursement for services not sanctioned by the plans.

- Providers often fail to offer areas of screening when these services are not explicity permitted for reimbursement under the state plan.

- Restrictions in the plans on the awarding of vendor status to community agencies limits the availability of supportive services and the potential for Head Start and similar groups to become service vendors.

POLICY CONSIDERATIONS:

- Development of uniform national standards for EPSDT plans, by types and levels of services, and provision for reimbursement might expedite and facilitate the relationship between Head Start programs and EPSDT.

- Consideration might be given to developing reimbursement procedures in state plans which permit payment for provision of specific services rather than an entire package, since a provider might be encouraged through this arrangement to perform procedures which might otherwise have been neglected.

- Clear and precise information on the operational and procedureal aspects of state EPSDT plans might be provided to Head Start programs, as well as to other agencies and consumers, in order to increase the efficient use of these resources and servcies.

- More effective integration of Head Start and EPSDT servcies might be accomplished through reveiw by SRS of Head Start's provision of the specific services rendered. Health liaison specialists may have an important role to play in this regard, through their active intercession between Head Start programs and local EPSDT/Medicaid agencies to promote closer and more efficient working relationships.

What were the income and expenditure costs associated with implementing the collaborative effort?

(Few projects submitted cost utilization data; findings are based on information from a limited group--response rate was less than 25%.)

FINDINGS:

- The average per child cost for those children--both Head Start and non-Head Start--served through the Head Start/EPSDT demonstration projects was $45.00.

- The supplemental grant represented 74 cents of every dollar generated/received by the Head Start/EPSDT demonstration projects in support of the collaborative effort. Likewise, the supplemental grant accounted for 75% of the total expenditures for the collaboration relative to all monies spent by the projects to implement the program.

- Forty-eight percent of all monies spent on the collaborative effort by the demonstration projects (including Title XIX monies as reported by the projects) were for direct, health-related services; 27% for supportive services, e.g., transportation of patients to and from the clinic site; and 25% for administrative services.

- Fifty-one percent of all health services received by the Medicaid certified population--both Head Start and non-Head Start participants--among the selected projects was paid for, in whole or part, by Medicaid. For Head Start children, Medicaid was involved in the payment process 50% of the time; for non-Head Start children the figure rose to 63%.

PROBLEMS:

- Lack of providers, failure to reimburse for certain services in accordance with a state EPSDT plan, and infrequent use of reimbursement for mental health and nutritional services may be contributing factors to Medicaid's limited participation in certain situations in the payment of EPSDT services for Medicaid certified children.

- Some lack of discretion regarding administrative costs may have had an adverse impact on the level of services provided.

POLICY CONSIDERATIONS:

- Review could be undertaken by the projects to determine how monies directed toward meeting the objectives of the collaborative effort could be maximized, and how monies directed to lower priority areas within the effort could be minimized.

- Projects might begin to develop a system containing provisions for identifying reimbursement areas and requirements. Such a system may also improve managerial procedures for the projects and may clarify objectives and methods of attaining them.

- Because of the unreliability of cost/revenue data, more emphasis might be placed on the retrieval of this information during the second-year evaluation.

- For the supplemental grant, monies might be more effectively distributed according to a formula that takes into account program size and other variables.

- Designation by the local/state Medicaid agency of the Head Start program as a provider of health services would ease reliance on the supplemental grant and would also facilitate service delivery (supportive and health-related) to the target population.

- Where such designation is not possible, programs may be encouraged to reach agreements with local health providers that are recipients of third party payments, to share in any monies received as a result of services delivered to children referred by the projects.

- A sliding fee scale system might be implemented, selectively, to facilitate payment for direct services (to non-Medicaid eligible families only).

What organizational/operational changes took place in the local projects in carrying out the collaborative effort?

FINDINGS:

- Minimal planning was done by the projects prior to implementation. Most used their proposal application as the basis for the operational plan.
- The majority of the projects hired EPSDT coordinators full-time, most of whom had some college background and several years of previous experience in Head Start.
- The Head Start Health Services Coordinator was responsible for the design, operation and administration of the collaborative effort. This additional responsibility often placed severe strain on existing staff.
- Non-EPSDT paid staff were used to carry out certain functions because of limitations of the supplemental grant and the need for additional staff resources.
- Technical assistance provided by Regional OCD to the Health Liaison Specialist was limited and primarily in the form of workshops or information provision.
- Many projects took initiative on their own to carry out the objectives of the collaboration.
- The greatest amount of innovation by the projects was in outreach.
- The relationships between Head Start projects and EPSDT agencies were informal and characterized by verbal agreements.

How could Head Start make more effective use of EPSDT as a program resource?

POLICY CONSIDERATIONS:

At The Federal Level

- The Head Start program could be more specifically geared to family health so that all siblings (and others in household) could be routinely involved in a well-defined developmental health program.
- Managerial procedures for local Head Start projects could be established to clarify the objectives of the collaboration with emphasis upon more effective resource utilization, e.g., shifting limited resources rather than maintaining high administrative overhead

At the Regional Level

- Technical assistance could be provided to local programs to improve their outreach activities and follow up on screened and diagnosed children as well as interactional relationships with EPSDT agencies.
- Standardized procedures could also be established for intake and follow-up, including recordkeeping.
- Information could be provided or the type and availability of EPSDT services--direct and supportive--and/or local providers

At the Program Level

- Specific training in coordinating and utilizing EPSDT services could be provided for all Head Start staff.
- Staff with particular expertise in skills related to EPSDT services could be employed, preferably on a full-time basis.
- The Head Start Parent Involvement Component could be an integral part of EPSDT collaborative activities, particularly for supportive servcies.

- Head Start projects could seek out community health resources which provide particular types of screening services unavailable through Head Start and thereby improve their utilization of community services and expand their service delivery capability.

- Head Start projects could press for changes in their state EPSDT plans to award vendor states to community agencies so that Head Start projects could be directly reimbursed for the EPSDT comparable services they provide.

Conclusions and Policy Considerations

This section summarizes the findings of the study as related to the three broad policy areas.

Can Head Start play a role in the delivery of preventive health services for preschool children through EPSDT?

Yes, for reaching and identifying potentially eligible Head Start families for Medicaid eligibility, and for recruiting non-Head Start children for EPSDT during campaigns to enroll children for Head Start.

Maybe, for preventive screening of Head Start families, provided there is service comparability with the state plan and institutionalized arrangements--including reimbursement for Head Start--for linkage into the EPSDT program and for follow-up activities.

Maybe, for comprehensive health care delivery, e.g., diagnosis and treatment as well as follow-up to assure these services through health providers. Further, Head Start resources now allocated for direct treatment could be shifted to other program use, provided services are available in the area.

Is EPSDT a viable resource for obtaining health services for Head Start children at present?

Maybe, for those children who are Medicaid certified, provided there is comparability between the EPSDT services and Head Start standards for health care.

Is the collaborative effort a model which is replicable nationwide?

Maybe, provided Head Start projects are given clear guidelines and adequate technical assistance and training on how to deploy existing staff, e.g., health and parent involvement, more effectively. Also, attention could be focused upon issuing standarized procedures for operation and recordkeeping.

Maybe, provided federal and state administering agencies for Head Start and EPSDT initiate planning activities to remove obstacles that exist at the regulatory level, e.g., differences in program standards; institutionalized relationships with community-based agencies such as Head Start.